

**IN-HOME SUPPORTIVE SERVICES PROGRAM  
NOTICE TO RECIPIENT  
APPROVAL OF EXCEPTION TO EXCEED WEEKLY HOURS**

(ADDRESSEE)

County of: \_\_\_\_\_

Notice Date: \_\_\_\_\_

Recipient Name: \_\_\_\_\_

Recipient Case Number: \_\_\_\_\_

IHSS Office Address: \_\_\_\_\_

IHSS Office Telephone Number: \_\_\_\_\_

To: In-Home Supportive Services (IHSS) Recipient

This notice is to inform you that your request for an exception to exceed your maximum weekly hours has been approved for the service month of \_\_\_\_\_.  
You may have your provider(s) work these additional hours. MONTH

You will need to adjust your providers' work hours by reducing an amount equal to the number of approved exception hours before the end of the month to make sure your monthly authorized hours are not exceeded. If you do not adjust your providers' work hours before the end of the month, your provider(s) will not be paid for the excess hours by the IHSS program, and you will be responsible for the payment of any service hours beyond your authorized monthly hours.

If you have any further questions about this notice, you may contact your county IHSS office at the phone number above.